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OCTOBER TERM, 1984

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STATE OF CONNECTICUT,  
DEPARTMENT OF INCOME MAINTENANCE,

*Petitioner,*

v.

MARGARET M. HECKLER, SECRETARY,  
and THE UNITED STATES DEPARTMENT OF  
HEALTH AND HUMAN SERVICES,

*Respondents.*

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**BRIEF OF AMICI CURIAE THE STATES  
OF ILLINOIS, CALIFORNIA, AND MINNESOTA  
ON BEHALF OF THE PETITIONER**

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The States of Illinois, California, and Minnesota as *amici curiae* respectfully join in the brief of the Petitioner State of Connecticut, Department of Income Maintenance, requesting that this Court reverse the decision of the United States Court of Appeals for the Second Circuit dated March 30, 1984.

## STATEMENT OF INTEREST

The States of Illinois, California, and Minnesota have a direct financial and public policy interest in the outcome of this case. Illinois, California, and Minnesota have been involved in litigation concerning the same disallowance of federal Medicaid funds that underlies the Second Circuit decision before this Court for review.

The Illinois Department of Public Aid, the California Department of Health Services, and the Minnesota Department of Human Services are the "single state agencies" designated to administer the State plans for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. §1396a(a)(5). The state agency draws up a medical assistance plan consistent with the guidelines contained in Title XIX and the regulations promulgated thereunder and submits it to the U.S. Department of Health and Human Services (HHS) for approval. Upon approval of the plan by HHS, the state becomes eligible for reimbursement for a portion of the expenditures made in providing specific types of medical assistance to eligible individuals under the plan. 42 U.S.C. §1396b(a).

There are two types of nursing homes qualified for federal funding for residents who are eligible for benefits under the Medicaid program—skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). SNFs care for individuals who need daily nursing services in a residential setting but who do not require an in-patient hospital placement. *See* 42 U.S.C. §1396d(f). ICFs care for individuals who, because of their mental or physical condition, require institutional services above the level of room and board, but who do not require the level of care

provided by a hospital or skilled nursing facility. *See* 42 U.S.C. §1396d(c). The disallowance of federal funds at issue here concerns nine ICFs in Illinois, five SNFs in California, and three ICFs in Minnesota. Until the disallowance, these States' expenditures for services provided to residents of these homes had been eligible for federal financial participation under Section 1905(a) of the Social Security Act, 42 U.S.C. §1396d(a)(15). Each state claimed and received federal funding for such services throughout this period.

However, in 1979 and 1980, the Health Care Financing Administration (HCFA) of HHS retroactively disallowed the federal financial participation on the ground that all of these nursing homes should be considered "institutions for mental diseases" (IMDs) as that term is used in Title XIX of the Social Security Act, 42 U.S.C. §1396d(a)(18)(B).

The States of Connecticut, Illinois, California, and Minnesota each filed an application for review of the disallowance with the Departmental Grant Appeals Board of HHS. The Board subsequently considered these applications in a joint proceeding before the Departmental Grant Appeals Board, with each state raising similar issues respecting interpretation of the statutory term "institution for mental diseases." On December 4, 1981, the Board issued its Decision Number 231 upholding the disallowances against all four states.

This retroactive disallowance resulted in the loss of federal funding to the States in the amounts of \$4,261,162 to Illinois, \$2,329,401 to California, and \$896,159 to Minnesota for this audit period. While this represents a substantial loss of funding to the states, it is clear that if the Second Circuit's decision is affirmed the future loss will be many times greater, resulting in the deprivation of medical services to needy citizens of the states.

## SUMMARY OF ARGUMENT

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The IMD exclusion should not be applied to facilities such as the Illinois, California, and Minnesota nursing homes involved in this case. Congress has indicated consistently that the term "institution for mental diseases" applies to mental hospitals. It has never given any direction that the term should be extended to nursing homes, which it has encouraged as alternatives to mental hospital care. The States of Illinois, California, and Minnesota adopt in full the arguments set forth by the State of Connecticut in its brief. The extension of the "IMD" exclusion to cover ICFs and SNFs is contrary to the intent of Congress in carving out the exception and to the position consistently taken by HHS. Moreover, the expansion of the IMD exclusion to ICFs and SNFs violates the spirit and purpose of the cooperative federal-state Medicaid program.

## ARGUMENT

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### **DISALLOWANCE OF FEDERAL FUNDS FOR NURSING HOMES IGNORES THE INTENT OF CONGRESS IN FORMULATING THE MEDICAID PROGRAM AND WILL DISRUPT THE ORDERLY ADMINISTRATION OF THE MEDICAID PROGRAM**

In *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), this Court stated that when Congress acts under its spending power, as it does in the Medicaid program, its authority to compel states to act is more limited than under those portions of the Constitution which give express substantive powers to the federal government. Requirements imposed under the spending power are essentially contractual in nature, with the states agreeing to certain conditions in return for federal funds. In *Pennhurst*, this Court stressed the requirement that states have clear notice of such conditions, so that they may make an informed decision of whether to agree to the grant prerequisites. Congress' power did not include the right to surprise states with retroactive changes in the conditions attached to the grant. *Id.* at 17-18, 24-25. Where Congress did intend to impose specific conditions on the receipt of grants, "it has proved capable of saying so explicitly." *Id.* at 17. It is fundamental that if Congress cannot retroactively change the conditions attached to a grant, HHS, in administering the congressional enactment, cannot do so either.

Since the beginning of the Medicaid program, the law has distinguished between institutions for mental diseases and nursing homes (intermediate care facilities and skilled nursing facilities). An IMD, as the states understood it from legislative history and earlier administrative prac-

tice, is a traditional state operated mental hospital or its "functional equivalent."<sup>1</sup> Each of the states involved in this disallowance maintains state mental hospitals into which it places persons who need that type of care and for which no Medicaid funds are claimed. The nature of these placements is totally unambiguous, because their population consists of people whose mental illness is so severe that they need to be institutionalized in a mental hospital.

In contrast, nursing homes provide certain levels of nursing care expressly delineated in the statutes and regulations to people not so severely disabled as to require mental hospital care. *See, e.g.*, 42 U.S.C. §§1396d(c), (f). There has been absolutely no showing that the audited facilities provided anything more or less than the care specifically required to be provided in intermediate care and skilled nursing facilities under Medicaid law, nor has it been claimed that the patients were not in need of such services. Based on this, the states legitimately believed that Medicaid funds were properly claimable for the services to these patients.

The audit underlying this case specifically reversed the states' legitimate expectations. No longer was an IMD a state mental hospital or its "functional equivalent." Suddenly, any skilled nursing facility or intermediate care facility would be branded an IMD if, after months or even years of poring over medical records, federal auditors concluded that the facility had too many patients with

<sup>1</sup> A "functional equivalent" of a state mental hospital would be a private psychiatric facility serving people with the same severity of mental illness as those requiring public mental hospital care.

"mental" diagnoses,<sup>2</sup> was located too close to a state mental hospital, advertised that it provided care for persons with mental disabilities, received patients who had formerly been in state mental hospitals, or one of several other criteria totally unrelated to the type of care actually needed and received by the patients.

There is no suggestion in any of the legislative history of the IMD exclusion that an IMD would be so difficult to identify, requiring the expenditure of large amounts of time and resources. Congress seemed to think that a facility's status as an IMD would be quite obvious, as indeed it always has been to the states and to the public.

Congress also believed that IMDs were essentially undesirable places. This is quite clear from the legislative history as discussed by the petitioner State of Connecticut. Because of this, Congress required that persons who truly did not need an IMD be given a type of care more appropriate for them. This might be non-medical care not eligible for federal funding, or it might be medical care in a Medicaid-eligible facility which provides such care. Nowhere did Congress suggest that all of those persons who many years ago were commonly warehoused in IMDs would still somehow carry an "IMD" label when they are now appropriately placed into facilities to provide them with required nursing care, or that this label would taint

<sup>2</sup> One of the most pernicious aspects of the federal audits to seek out IMDs was the amazingly over-inclusive selection of patients for the label of "mental diagnosis". Auditors included persons suffering from senile dementia, alcoholism, brain trauma, brain damage due to drug overdose, psychotic behavior due to high fever, and similar conditions among those Medicaid recipients whose presence in a nursing home "proved" that the nursing home was an IMD.

those facilities to deprive them of Medicaid funding. Yet that is precisely the effect of the policy HHS seeks to vindicate in this action.

The states before this Court have struggled to provide better and more appropriate care for their mentally disabled residents than used to be the norm not so many years ago. In doing so, they have operated state mental hospitals (now much improved from their former "warehousing" function) for those patients who need such focused psychiatric care. No federal funds are claimed for these patients between the ages of 21 and 65.

For those patients who properly need routine skilled nursing care or intermediate care rather than confinement in a state hospital, the states have ensured access to private facilities providing such care. That is precisely what Congress required the states to do, and there is nothing in the legislative history which suggests that the states' compliance with Congress' will would remove the private facilities which provide this care from Medicaid eligible provider status.

It is important to recognize that this is *not* a case where HHS auditors found that the patients in these facilities did not need the care of skilled nursing or intermediate care facilities, or found that the services provided did not meet the requirements for such services found in Medicaid law.

What has happened here is quite different. These were not truly audits but rather the *ex post facto* gathering of data to justify a new policy. Learning that states had been placing into more appropriate environments those patients who would formerly have had nowhere to go but a state mental hospital, HHS somehow saw a state plot

to raid Medicaid funds. That attitude, which is quite clear from the documents produced before the HHS Departmental Grant Appeals Board, led to a redefinition of the term "institutions for mental diseases" and to the audits which began this case.

In cases such as *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), this Court has recognized that states administering the many federal grant programs are in a uniquely vulnerable position. In order to claim and retain funds, they must administer complex programs with myriad detailed requirements, always at risk that the federal government, program beneficiaries, taxpayers, or some other interested party will claim that less or more money should have been spent. At the same time, states must budget their operating funds as best they can. This process is incredibly complex and difficult at best. If HHS can add to this the retroactive definition of what is and is not properly a Medicaid-eligible facility, the administrative difficulties become insurmountable. This Court has held in *Pennhurst* that states cannot lawfully be forced into this position by the federal government.

*Amici* states of Illinois, California, and Minnesota urge the Court to reaffirm that holding in this context and ensure that the legitimate expectations of the states which participate in the Medicaid program are not abused. To allow HHS to proceed as it has done with disallowances of federal funds claimed by states for ICFs and SNFs would totally disrupt the states' orderly administration of the Medicaid program and create a precedent for retroactive defunding of legitimate costs.

## CONCLUSION

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For the reasons stated in this brief and in the brief of the petitioners, *amici* respectfully urge this Court to reverse the decision of the court below.

Dated: January 2, 1985

Respectfully submitted,

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